SOCIAL ACTION

Is Health the Public's Business?

by James Rorty

. III, No. 6

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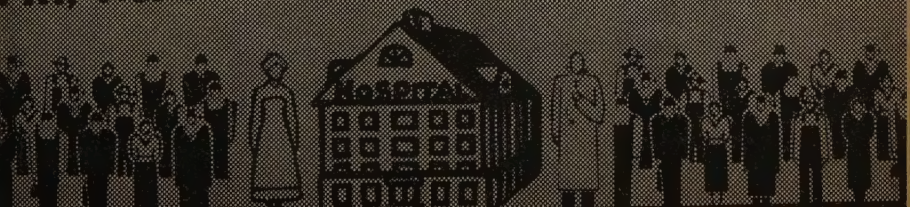

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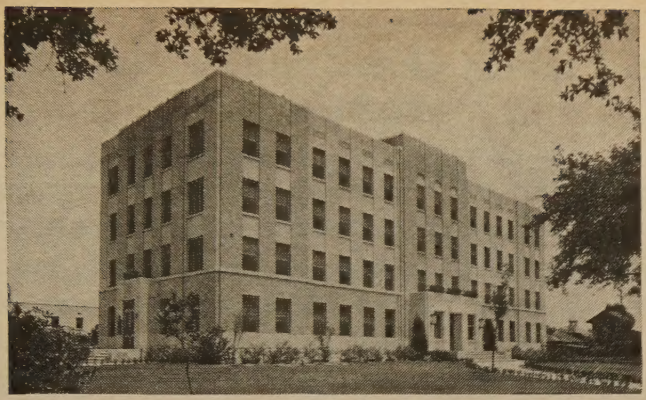

The Flint-Goodridge Hospital for Negroes in New Orleans, Louisiana, supported by Methodist and Congregational Boards

FOREWORD

The Church is concerned with the physical well-being of all men. It has always accepted the ministry of healing as part of the essential gospel of Jesus "who healed many that were sick of divers diseases." The hospitals and clinics now endowed and supported by the Congregational and Christian churches are evidences of our belief that religion is concerned with bodily health.

This study of Mr. Rorty's is therefore primary factual material for churchmen who have long felt it imperative that health services should be made available to those in need, and who have already demonstrated in positive terms that they will cooperate in serving those in need.

Mr. Rorty has done extensive research on America's problem of providing adequate medical care for all people, and is the author of a book on medical economics and politics which will be published early in the fall. His other published works include OUR MASTER'S VOICE: ADVERTISING, ORDER ON THE AIR, WHERE LIFE IS BETTER: AN UNSENTIMENTAL AMERICAN JOURNEY, and articles in such magazines as *Harper's, Scribners, The Nation,* and *New Republic.*

The views expressed in this study, as in other *Social Action* pamphlets, are those of the author. They are presented to our church constituency and to the public as a contribution to the understanding of a serious social problem.

—HUBERT C. HERRING

Is Health the Public's Business?

By James Rorty

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THE publicly employed health officer and the garbage collector are accepted as public necessities in most American communities. Hence, few people would answer "no" to the question posed in the title of this pamphlet, even though, as we shall see, the full implications of a "yes" answer have not been generally recognized. Health is the public's business.

To a greater or less extent this has always been so, even in primitive societies. And surely we have come to the time when it can be said that *the degree to which health is made the public's business is one of the most exact measures we have of the social, political, and cultural level of a given civilization.* Sir Arthur Newsholme says, in *Medicine and the State:*

> "Civilized communities have arrived at two decisions, from which there will be no retreat, although their full realization in experience has nowhere been completely achieved. In the first place, the health of every individual is a social responsibility; and secondly, as following from this, medical care in its widest sense for every individual is an essential condition of maximum efficiency and happiness in a civilized community."

Measured by this yardstick, where does America stand?

It stands very high with respect to our investment of social capital (public and philanthropic funds) in medical schools, research institutions, hospitals, and laboratories. High with respect to the average training and competence of our doctors, dentists, nurses, and other health workers.

It stands low, disastrously low, with respect to the organization of our health services and the careful budgeting and use of our health expenditures. Low, lower than many far poorer

countries, with respect to the minimum protection and care available to the majority of our sick people.

For many years it has been the considered judgment of practically every student of the problem that families with an income of less than $3,000 a year cannot afford to "pay-as-they-go" for medical care. Illness strikes too unequally, too unpredictably, and the cost of a disabling illness, both in doctors' bills and lost working time, is likely to be too great. The common sense answer to the problem of health is to apply the principle of insurance to the payment of medical costs.

Yet America is today the only civilized country in the world which has thus far failed to adopt compulsory health insurance, state medicine, or some combination of the two as the only possible means of securing adequate medical care for all the people.

The result is stated by Dr. Ray Lyman Wilbur, Secretary of the Interior in the Hoover administration and a former president of the American Medical Association, as follows:

> "The lack of adequate medical service lays a burden of pain, suffering and inefficiency on this nation which, rich as it is, exceeds what we can afford. The question which faces the American people in the next ten years is not whether we can afford to provide ourselves with satisfactory medical service, but rather, whether we can afford to provide less than adequate medical care."

The Chaos In Our Health Services

Unmet Medical Need

IN the prosperous year of 1929, the Committee on the Costs of Medical Care (composed of 48 members including 27 physicians, with Dr. Ray Lyman Wilbur as chairman) found

that we spent about $3,700,000,000 for medical care of all kinds—an average of $30 per capita, and of $108 per family. If properly expended, that sum would be enough or almost enough, according to competent authorities, to purchase adequate medical care for all our people.

But what did we get for it? The dark picture painted by the Committee on the Costs of Medical Care has not changed essentially since 1932, when the Committee reported the results of its five years of research. Here are a few of the most significant findings in this and several other investigations:

(1) From 25 to 30 per cent of all cases of relatively serious illness never come under the care of a physician.

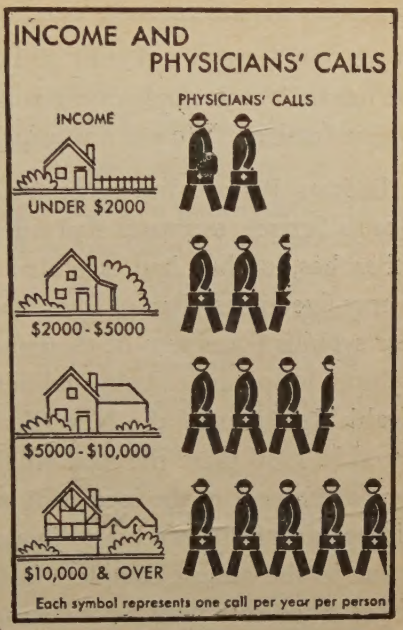
(2) In any given year about half the families with incomes of less than $2,000 receive no medical care whatever, although because of poor housing, undernourishment, and occupational hazards, this is precisely the class that requires *most* medical care.

(3) Poor families postpone calling the doctor; workers report at work—because they are paid by the day—when they should remain at home under medical care. *The average number of days spent in the hospital by the poor patient is nearly twice as great as that of middle and upper class persons.* Too often the poor enter the hospital on stretchers, and if they survive, come out as chronic sick, unable to support their families, who become public dependents.

During the depression a committee of the American Association of Medical Social Workers reported that:

> "The relief stations are besieged by persons seeking medical care for conditions which might have been prevented by an

active public health service or by effective treatment of diseases in their earlier stages. The findings of the study substantiated the fact that is already well-recognized—namely that medical resources are nowhere adequate for the curative and preventive treatment of illness. . . ."



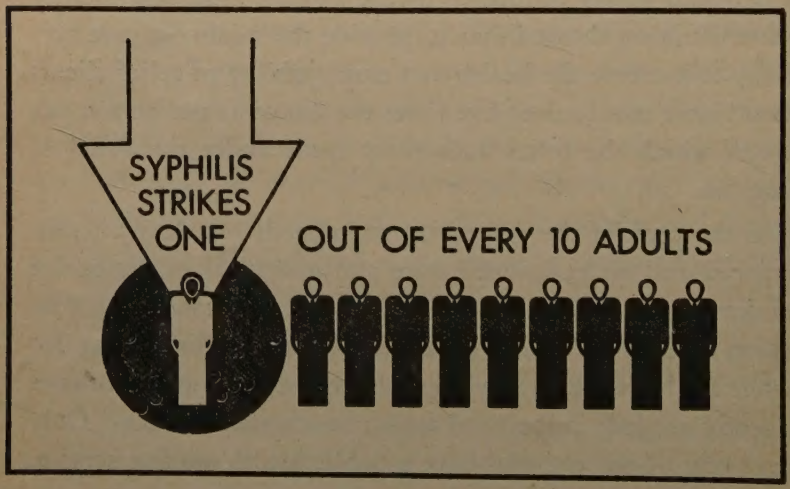
The same report speaks of "the utterly unsolved problem of dental care," "the almost total lack of facilities for chronic, convalescent care," and the failure to provide immunization against typhoid, diphtheria, scarlet fever, and other contagious diseases.

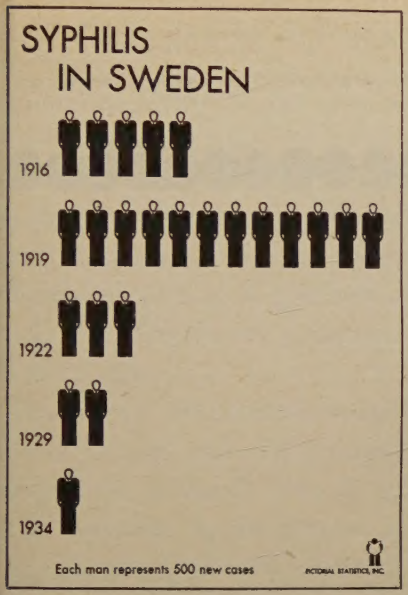
A health survey conducted by the Federal Emergency Relief Administration showed that to provide the minimum care necessary to preserve the health and employability of relief clients would have cost four or five times the ten cents per person per month which the relief authorities spent under the F.E.R.A. program.

At the peak of the depression our already hopelessly underfinanced and under-manned state and municipal public health services were reduced by over 20 per cent. According to Professor C. E. A. Winslow of Yale, we are spending today for public health work in the cities about one-third as much as is urgently needed; in the rural areas one-seventh as much. Only 9 per cent of our counties have a public health nursing service.

If we put twenty times as many public health nurses at work as we now have, we should still have barely enough to meet the need. Yet unemployment is today widespread in the nursing profession. We are not using available facilities.

Thomas Parran, Jr., Surgeon General of the U. S. Public Health Service, estimates that one out of every ten Americans either has, or has had, syphilis. Our syphilis rate is fully twenty-five times that of the Scandinavian countries. Every year syphilis pours tens of thousands of victims into our insane asylums, hospitals, and alms houses. The Committee on Public Health Relations of the New York Academy of Medicine declared in 1936 that "the past indifference of the public and of our government to the increasing prevalence of these, the most widespread of all infectious diseases (syphilis and gonorrhea), is due to the almost complete ignorance of the problems and of the huge cost with which we are burdened because of its neglect." Yet syphilis could be eradicated, according to Dr.





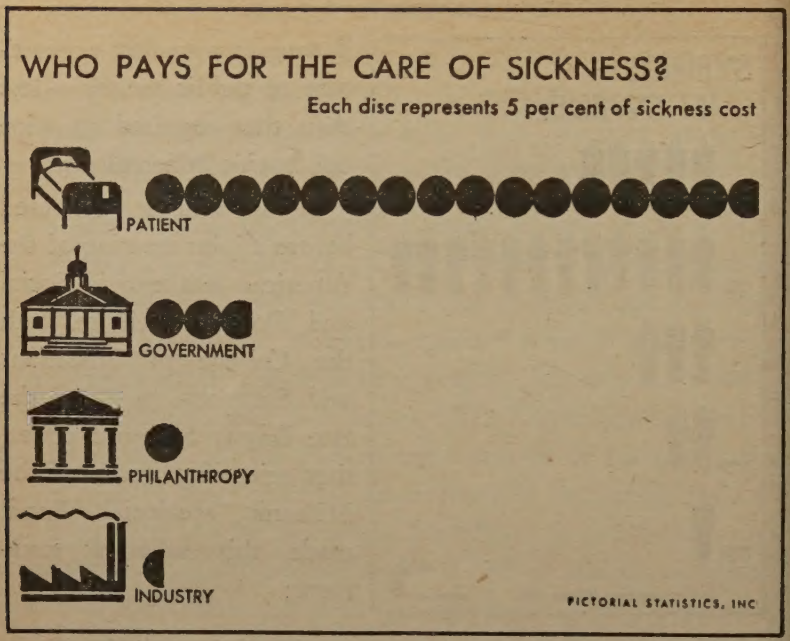
Parran, by a modest expenditure of public money — less than that required to wipe out bovine tuberculosis.

In an address delivered before a joint meeting of the American Academy of Social and Political Science with the College of Physicians and Surgeons, in 1934, the late Edgar Sydenstricker, then scientific director of the Milbank Memorial Fund, made this sobering statement:

> "In a year's time, even in a prosperous era, millions of families cannot afford to obtain any medical care; hundreds of thousands of cases of illness requiring medical attention are unattended; less than 7 per cent are immunized against some disease. . . . Although we are accustomed to boast of our achievements in medicine and public health as manifested in a lowered mortality rate among infants, children and younger adults, the death rate among adults of middle age and old age has not appreciably diminished in the past fifty years. Even the mortality rate among mothers and infants in a large class of the population of the United States is still far above that in some other countries."

Unbalanced Health Expenditures

USING the figures published by the Committee on the Costs of Medical Care, we find that of the $3,700,000,000 we spent for medical care of all kinds in 1929, the patients paid 79 per cent, government 14 per cent, philanthropy 5 per cent,



and industry 2 per cent. Note that 79 per cent of the costs are borne entirely by individuals, except in so far as the high fees charged to rich patients enabled doctors to charge low fees to poor patients or to provide free care. Through this practice some medical costs are more equitably shared on the basis of ability to pay.

Another set of percentages is even more revealing. Of that $3,700,000,000 the physicians got 29.8 per cent, the hospitals 23.4 per cent, the medicine makers and distributors 18.2 per cent, the dentists 12.2 per cent, the nurses 5.5 per cent, the "cultists" 3.4 per cent, and the public health service 3.3 per cent.

Note that the public health services, with 3.3 per cent, come at the bottom of the list. Yet it was the organized attack, led

by the public health services, upon the major causes of infant and adult mortality that played the largest role in reducing our national mortality 25 per cent between 1900 and 1932. The above figures are given by Professor Winslow, who points out in an article in the *Survey Graphic* that "It can scarcely be an accident that the four diseases which are so strikingly diminished (typhoid, diphtheria, and infant diarrhea over 90%, and tuberculosis 60%) are precisely those diseases which have been made the objective of organized attack by the health forces of the country."

The public health services spend money chiefly for *prevention* of disease, and it is precisely such expenditures that yield the highest dividends both in terms of money and of health. C. C. Lumsden, Senior Surgeon of the U. S. Public Health Service, is authority for the statement that the investment of public funds in public health work yields dividends of from 100 to as much as 3,000 per cent. Yet we give the public health services only a 3.3 per cent cut out of our national health expenditure! We spend nearly three times as much on nostrums and patent medicines ($350,000,000 a year) as we spend on the immensely productive work of our public health agencies.

Cultists and Patent Medicine Makers

THE so-called "secular" healers and "cultists" run all the way from honest men who are attempting to establish genuine scientific disciplines and professional standards, and who are seeking to integrate their admittedly limited contribution into the accepted body of medical knowledge and skill, to outright quacks and charlatans. We have 36,000 of these secular practitioners in the United States—about eighteen times as many as the total number found in all other countries. We pay

them $125,000,000 a year—3.4 per cent of our total health expenditures—slightly more than we spend on our public health services.

These statistics are highly significant. It might almost be said that the secular medical practitioner is specifically an American phenomenon. There are, of course, a variety of explanations of this phenomenon, but if our health services were reasonably well-organized and provided even approximately adequate medical care for all our people, the best of these practitioners would be fully recognized and employed whereas the worst of them—the quacks—would be competed out of business.

This is equally true of the nostrum-makers. Unintelligent self-medication, rightly denounced by the organized medical profession, is caused both by ignorance and by the inability of poor people to pay for medical service. The patent-medicine manufacturer will continue to make good his boast that he is "the poor man's doctor" until a fundamental re-organization of our health services makes adequate medical care available to all our people.

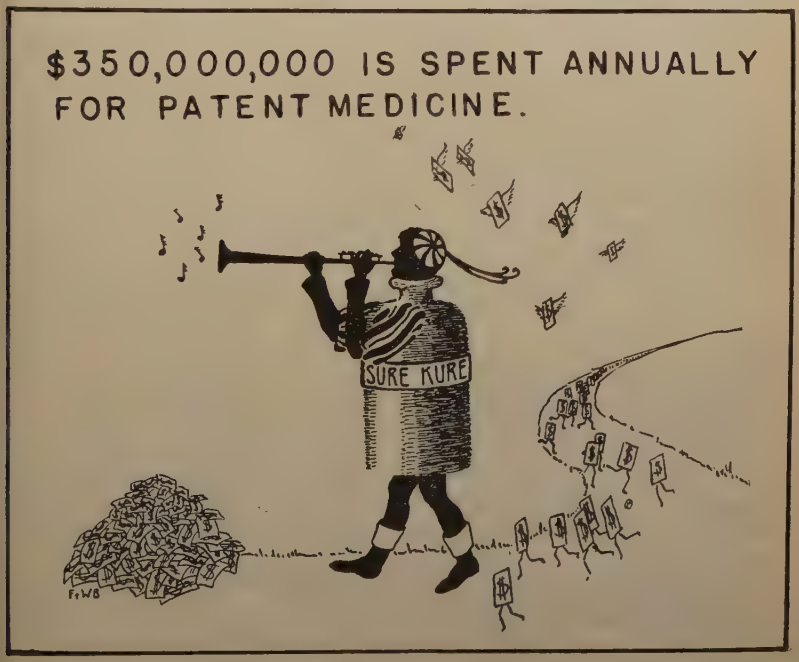
Meanwhile we spend $715,000,000 a year for medicines, or $5.50 per capita. Of this sum, $350,000,000 is spent for patent medicines, most of them worthless, or worse. The remaining $365,000,000 also includes a considerable percentage of waste as well as exorbitant profit-making by manufacturers of the so-called "ethical proprietaries," such as *luminal,* advertised only to doctors. Many, if not most, of these are identical with basic prescription pharmaceuticals costing one-fourth as much, as the Council on Pharmacy and Chemistry has repeatedly pointed out.

Impossible Health Hazards

BECAUSE of the unequal and unpredictable incidence of illness, especially disabling and costly illness, it is next to impossible for families of moderate or low income to budget the cost of medical care, in other words, to pay for medical care as individuals out of income. In *Health Security and the American Public,* Dr. Michael Davis, of the Rosenwald Foundation, writes:

> "An unlucky sixth of our people . . . pays in one year half the total sickness paid by everybody in that year. . . . No one can tell in advance whether his family, during the next year, will be in the lucky half, the moderately lucky third, or the unlucky sixth."

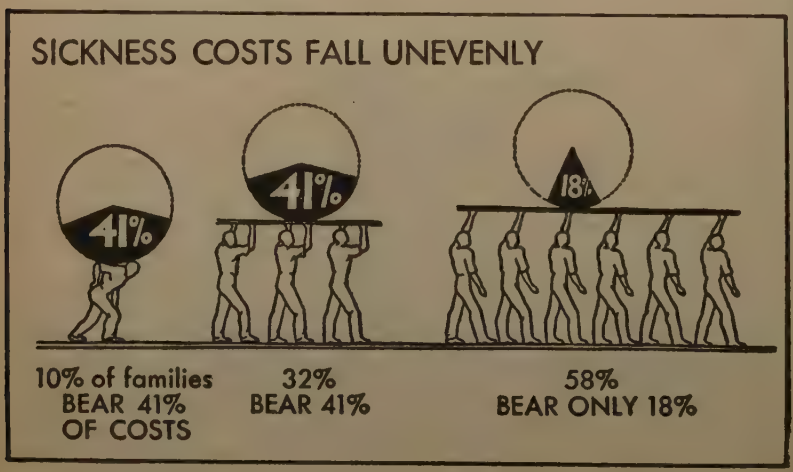
The middle or upper middle class family can ordinarily afford a little hard luck of this kind. The working class family



cannot. It has long been recognized that sickness is the leading cause of dependency.

When a wage worker gets sick, his pay stops at the same time that his medical bills mount. His savings, if any, are soon exhausted. Sooner or later the home is lost. A look at the case records of any charitable or relief agency will soon convince the skeptic that this experience is typical.

The public hospitals, the free wards and out-patient departments of the private hospitals, and the traditional free care given to poor patients by private doctors all tend to meliorate this situation somewhat. But not enough. The city hospitals and free private wards are overcrowded. The financial condition of the private hospitals does not permit them to give sufficient free care, even though many of their private beds may be empty. And private physicians are torn between the need to provide their own families with a living and the demands of a horde of fee-less patients whom they can scarcely serve, even with the best will in the world.



Waste of Life and Money

MONEY wastes, however, are relatively unimportant—we are a rich people and possibly can afford them. What we cannot afford is the waste of human life and the huge burden of public dependency which the chaos of our health services inflicts upon us.

We do not know with any exactness how much sickness it might be possible to prevent if the demonstrated potentialities of preventive medicine were fully applied; nor is it possible to assign any exact money measure to the value of human life. This much, however, is agreed upon by most competent authorities: *that if we provided adequate medical service for all of our people, we should probably save more by so doing than we spend for the hopelessly inadequate, wasteful, and chaotic service we now have.*

In *Security Against Sickness,* Dr. I. S. Falk, who was director of the research staff of the Committee on the Costs of Medical Care and is now director of health studies for the Social Security Board, estimates our annual capital loss in terms of preventable sickness and death at about 6 billion dollars, as compared with 3 2/3 billion dollars spent for medical care. This loss, says Dr. Falk,

> "represents sheer loss because it is preventable through the proper expenditure of comparatively small sums in preventive work. It does not ordinarily arouse great anxiety, because the money value of human life is not generally recognized and because the loss is indirect rather than direct."

In that six billion dollar estimate of annual capital loss are included a variety of detailed estimates: (1) the losses to industry through lost working time and needlessly high labor

turnover because of preventable sickness, and the failure to eliminate industrial hazards, such as silicosis; (2) the lag, leak, and friction of our school system because children are kept out of school by preventable sickness; (3) the mounting bill for public dependency, much of which is traceable to preventable sickness and preventable deaths of bread-winners—these and many other losses.

Some of them could be materially reduced by modest expenditures and minor changes of our present system. But *the bulk of this huge loss can only be overcome by a fundamental reorganization of our health services, both in terms of administration and of the method of paying medical costs.*

Victimized Doctors

It is scarcely an exaggeration to say that the average private physician is himself among the most unfortunate victims of the chaos of our health services.

The Committee on the Costs of Medicine Care found that in 1929 the average net income of American physicians was $5,300. But this average had dropped 38 per cent by 1932, and by 1937 had by no means returned to the 1929 level. And for every doctor who netted $10,000 a year there were two who netted less than $2,500; for every dentist who netted $10,000 there were four who netted less than $2,500. The overhead of the average doctor's office is 40 per cent. Under our present "rugged medical individualism" each doctor must personally carry this excessive and socially wasteful overhead.

Traditionally, the private physician gives a portion of his

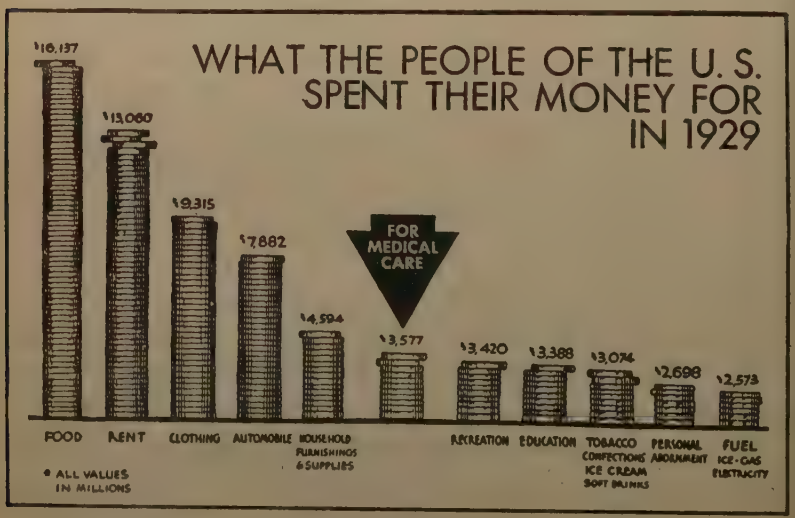
time to the service of the poor in free clinics and hospital wards. His only compensation for this service is the prestige of a hospital appointment and the clinical experience afforded. This system has produced endless conflict and confusion; yet it is continued, partly because of the impoverishment of municipal and private hospital budgets, and partly because of the organized profession's dread of "state medicine." With due allowance for the excellent work done in many free clinics, it may be said in general that the "clinic mills" as now organized grind crudely and too fast. Thirty patients per doctor-hour is scarcely "medicine" in the modern sense of the word. Until clinic facilities are enlarged and doctors paid for their services, it would seem impossible to establish and maintain adequate standards.

During the depression some thousands of doctors were forced to ask for public relief, usually extended in the form of payment for their service in the hastily improvised systems of medical relief given to F.E.R.A. and W.P.A. workers. In many cities (Los Angeles, Detroit and Dayton, Ohio, for example) the local medical societies brought pressure to bear which resulted in the closing of clinics and the transfer of the clinic patients to the private offices of the doctors, who were paid minimum fees out of public funds. In Los Angeles, an elaborate system of public health centers, representing an investment of $6,500,000 was closed at the behest of the local medical society. The system which replaced these health centers, which had been regarded as the pride of the American public health movement, proved both more costly to the public purse and less adequate judged by medical standards.

Should Medicine Be "Socialized"?

LIKE most necessary and ultimately inevitable reforms, the health insurance movement has suffered because of the "red herrings" that have been dragged across its trail. Yet there is really nothing "socialistic" about even the most extreme proposals thus far made with respect to the organization of our health services. Even if we decided to make medical care for everybody a public function, paid for out of taxes, we should be doing nothing more radical than we did about a century ago when we established compulsory public education. We took this step because we decided that, as a people, we could not afford illiteracy. We should today be much better off if we had decided at the same time that we could not afford preventable illness.

Surgeon General Parran has said that "In public health we stand today where we were in public education in the middle



of the last century." One might add that the longer we stand there, the bigger health deficits we shall accumulate.

Most of the changes currently proposed are purely administrative in character. This is true of group practice, of the closer integration of public and private health agencies, and of voluntary health insurance, all of which were recommended in the majority report of the Committee on the Costs of Medical Care.

Even compulsory health insurance is "socialized medicine" only to the extent that in most such systems the state contributes a share of the premiums. But since the bulk of the cost is carried by the insured workers—directly through the check-off of his wages and indirectly through the adding of the employers' contribution to the price charged to the consumers of goods and services—compulsory health insurance can scarcely be said to re-distribute income or otherwise advance the principle of socialization appreciably. In fact, compulsory health insurance has invariably been regarded in other countries as a device for avoiding state medicine.

It must also be recognized that compulsory health insurance does not solve, except indirectly and to a limited extent, the problem of providing medical care for the indigent. What it does do, is to provide a minimum guarantee of medical care and disability benefits for employed workers in the lower-income brackets. But this guarantee is highly important and valuable, both to the insured workers and to the community which, as already pointed out, pays a needlessly big bill every year in terms of the costs of preventable sickness and death, and of public dependency caused by preventable illness.

Compulsory health insurance must, of course, be supple-

mented by the public care given to the unemployed and the indigent, either directly or through subsidizing their participation in an insurance system.

Group Practice

IN OUR society, medicine is both a science and a business; the doctor is both a professional man and a business man. But neither the science nor the business of medicine can be conducted efficiently on an individualistic basis whether from the point of view of the doctor or of the patients. The body of medical science is huge, ramified, complex. No single mind can grasp it; no single pair of hands can administer it.

The essence of modern medical service is the efficient, economic use of available hospital, laboratory, and consultative resources. This is especially true of preventive medicine, with its emphasis on complete physical examination and early diagnosis. The general practitioner and his intimate relation to the family he serves is more important than ever. It is equally important that he be in a position to put at the disposal of his patients, as cheaply as possible, the full scope of this complex and highly specialized medical science.

So important did the extension of group medical practice seem to the Committee on the Costs of Medical Care, that in the majority report of that Committee it is recommended:

> *". . . that medical service, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably, around a hospital, for rendering complete home, office and hospital care. The form of organization should encourage the maintenance of high standards and the development or preservation of a personal relation between patient and physician."*

This recommendation represented merely a logical extension of the tendency toward group practice which has been steadily developing both in this country and abroad. The Committee had made careful studies of such developments. C. Rufus Rorem concludes one of these studies (Publication No. 8 of the Committee on the Costs of Medical Care) with this statement:

> "Private group clinics, through their available equipment and their coordination of medical specialists, are in a position to fulfill the basic requirements of good medical care with economies from which either or both the clinic members and the public may benefit."

It is important to distinguish between the various existing types of group practice. Some group practice organizations, for example the famous Mayo Clinic of Rochester, Minnesota, operate on a fee-for-service basis, like the ordinary individual practitioner. Others, such as the highly successful Ross-Loos Clinic in Los Angeles, apply the principle of group prepayment or voluntary health insurance, and offer to supply complete medical service to their subscribers at from $25 to $30 a year. The Ross-Loos clinic is a private medical partnership.

The Farmers Union Cooperative Hospital of Elk City, Oklahoma, is a medical cooperative, and quite different. It is owned and controlled by its members, who make an initial minimum investment of $50 in the form of payment for a share of stock in the cooperative enterprise. In addition to this investment, the member pays a family rate of $25 a year for complete medical care. Although this rate is increased by various extra charges in connection with both home care and hospitalization, it remains sufficiently low to attract a steadily increasing membership.

While voluntary health insurance through medical cooperatives is well-established in Europe, especially in the Scandinavian countries, it is barely beginning in America. The Cooperative League of the United States now has a Medical Bureau, headed by Dr. James M. Warbasse, dean of American cooperators, which is stimulating such developments. Similar efforts are being made by the Twentieth Century Fund and other philanthropic agencies.

Group Hospitalization

RATHER belatedly, and at prices which restrict participation to middle class families, group hospitalization came to America during the depression and is now growing rapidly. Pushed by the American Hospital Association and the American College of Surgeons, and reluctantly accepted by the American Medical Association, the idea of applying the insurance principle to hospital bills was instantly accepted by the lay public. By February 1, 1937, more than 750,000 subscribers were placing hospital care in the family budget by paying subscriptions of 50 cents to 85 cents per month per person. In New York City alone, as of that date, there were 225,000 subscribers to New York's 3 cents-a-day plan, in which over 200 hospitals participated.

It must be sharply emphasized that group hospitalization covers hospital bills only. No provision is made for the payment of medical and surgical service, except on the ordinary fee-for-service basis. Moreover, it becomes apparent when we compare the Ross-Loos and Farmers Union Hospital charges for *complete* medical service with any of the group hospitaliza-

tion prepayment fees, that these latter fees are by no means low for the limited protection afforded.

Group hospitalization had its origin in the depression when the private hospitals were very generally in financial distress owing both to the decrease of paying patients and to the reduction of philanthropic contributions. Group hospitalization offered a means of transferring some of the hospital overhead to the middle class patients, many of whom could not afford to pay regular hospital rates out of income but could afford to pay on an annual prepayment (insurance) basis.

Undoubtedly group hospitalization for middle class patients represents a step in the right direction. But the idea that it is in any sense a solution of the basic problem of making sense out of our health services must be unqualifiedly rejected.

Voluntary versus Compulsory Health Insurance

WE MUST also reject the idea that *voluntary* health insurance, no matter how complete its provision of medical benefits, can solve the problem. The majority report of the Committee on the Costs of Medical Care states that "Families with low or irregular incomes, even if they are self-supporting while employed, cannot usually be covered by any form of voluntary health insurance."

In *The Way of Health Insurance,* A. M. Simons and Nathan Sinai declare that

> "Every attempt to apply the principles of voluntary insurance on a large scale has proved to be only a longer or shorter bridge on the way to a compulsory system."

In other words, compulsory health insurance, with the employer and the government helping the workers to pay the

premiums, is necessary in order to provide a financial basis for the re-organization of medicine along more efficient lines.

The European Experience

DR. FALK bases the above conclusion on an admirably thorough digest and analysis of the experience of Germany, England, Denmark, and France in struggling with the problem of organizing their health services and of delivering a minimum of medical care to their respective peoples.

In all four countries voluntary health insurance, of greater or less scope, preceded the adoption of compulsory systems. In all four, *the improvement in the health standards of the populations and in the average compensation and financial security of the physicians has been fully demonstrated.* In all four, but especially in England and France, the initial resistance of the organized medical profession to the adoption of a compulsory system has been strenuous. In all four, once the battle was won, invariably by the mobilization of lay pressure groups, especially organized labor, the physicians suddenly discovered so much merit in the innovations which they had opposed that thereafter the organized medical profession has itself tended to lead the movement for widening the scope of medical benefits and otherwise extending and entrenching the compulsory system.

Germany has had compulsory health insurance since 1885, England since 1911. The German experience was excellently summarized in an address by Dr. Henry E. Sigerist, formerly of the University of Leipsig and now of Johns Hopkins University, delivered in 1934 before the American Academy of Social and Political Sciences. Said Dr. Sigerist:

> "It has been repeatedly pointed out that the average number of days of sickness has increased enormously since sickness insurance was introduced (in Germany). . . . This does not mean that the population is less healthy, or that there is malingering. It is not that the days of sickness have increased, but the days of treatment. Many illnesses that had gone untreated formerly today are given medical treatment in time, preventing fatal consequences. The general health conditions have undoubtedly improved tremendously, and this is illustrated by the fact that shortly after a lost war, famine, revolution, inflation, and all the disturbances of a postwar period, the German health conditions were just as good as in the best situated, victorious countries. . . ."

Concerning the British experience, it is sufficient to quote a resolution passed by the British Medical Association ten years ago and followed by other similar resolutions:

> "The measure of success which has attended the experiment of providing medical benefit under the National Health Insurance Acts system has been sufficient to justify the profession in uniting to secure the continuance and improvement of an insurance system."

In general, it may be said that *in no country in the world which has adopted health insurance is there disposition on the part of either patients or doctors to abandon it.* On the other hand there is continuous pressure by both medical and lay pressure groups to extend the system, correct its deficiencies, and increase the scope and quality of its benefits.

Opposition To Health Insurance

EVERY social movement designed to achieve basic reforms goes through three phases: first, fact-finding and analysis, secondly, the proposing and debating of alternative solutions, thirdly, social and political conflict. The movement for compulsory health insurance in America is now in this third phase,

and we have every reason to congratulate ourselves that we are at least that far along.

Invariably, in this third phase, the vested interests opposing the movement play a self-defeating role. By restoring to indefensible methods of fact-faking, lobbying, and obstruction they succeed finally in outraging public opinion to such a point that the passage of the necessary legislation becomes practicable.

In the case of the health insurance movement, the opposition comes from three principal sources: first, "organized medicine," meaning the American Medical Association and its state and local units; secondly, the so-called secular practitioners of the healing art, specifically the chiropractors, naturopaths, and faith healers; thirdly, the manufacturers and distributors of drugs, medicines, and medical equipment.

The Role of Organized Medicine

IF THE British and European experience is any criterion, there is every reason to expect that a well-planned system of compulsory health insurance, supplemented by an expansion and co-ordination of the public health agencies, would not only raise the health standards of our people, but would materially improve the financial and professional status of the medical profession as a whole.

Why, then, has organized medicine fought practically every change in the forms of medical practice that has been proposed during the past twenty years? Why did Dr. Morris Fishbein, editor of the *Journal* of the American Medical Association, denounce as "socialism, communism, inciting to revolution" the mild recommendations embodied in the majority report, signed by a majority of the doctors of the Committee on the Costs of Medical Care? Why is the discussion of medical economics

that goes on in the medical press characterized by inflamed emotion rather than by the objective, disinterested logic which one would expect from a profession trained in scientific method? Why did the American Medical Association force the exclusion of health insurance from the Social Security Act and boast publicly that it had done so? Why has there developed so profound a cleavage between many of the most distinguished figures in American medicine—men like Dr. Ray Lyman Wilbur, Dr. Hugh Cabot of the Mayo Clinic, and Dr. Henry E. Sigerist of Johns Hopkins—and the elected and appointed representatives of the organized profession?

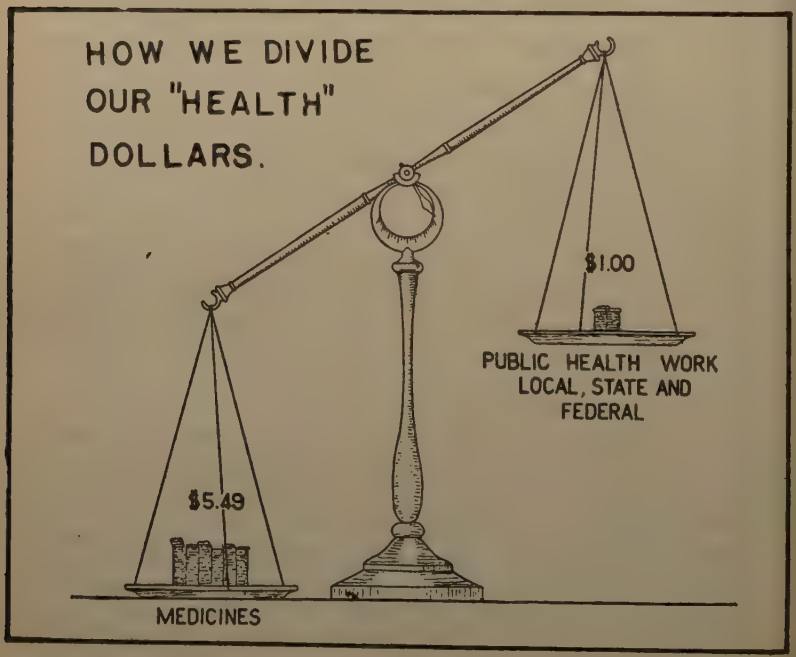
The lay public must understand this cleavage, if only to avoid unfair judgments reflecting upon the intelligence and public spirit of the average American doctor. The fact is that the American Medical Association is governed by a more or less self-perpetuating hierarchy of the older and more prosperous physicians, in whom the traditional conservation of the profession finds its most recalcitrant expression.

Concerning the younger and more progressive doctors, it may be said with some confidence that most of them want change and understand the course that change must take. But they are dependent upon their elders for professional advancement—especially for such things as hospital appointments, which are essential to successful practice. And the history of medical politics is lurid with the penalties imposed upon medical heretics by their colleagues. With the exception of such minority left-wing movements as the League of Socialized Medicine it is, in general, only the securely placed physicians who can afford the luxury of expressing progressive views publicly.

The extent to which the American Medical Association does not reflect the attitudes and convictions of the rank and file of American doctors has been recently revealed in a two-volume study entitled *American Medicine-Expert Testimony Out of Court,* published by The American Foundation. In this study some 5,000 letters from 2,200 leaders in medicine—38 per cent of them general practitioners—present the views of doctors on the sad state of American medicine and the manner in which it should be improved to meet an insistent demand for scientific care as a matter of human right.

Says the *New York Times* editorially (April 4):

"It is now doubtful if the entrenched officers of the association (A.M.A.) truly speak for organized medicine . . . the association through its journal advocates a policy of letting



medicine evolve naturally (while millions lie ill without adequate care or die because it costs too much to have a doctor) and regards the practice of medicine as a vested interest akin to that of a plumbers' union in the installation of bathtubs or kitchen fixtures. . . . If, as the Foundation makes it clear, the practice of medicine needs continual revision in the light of new community needs it is evident that social and economic change cannot be ignored. Yet the American Medical Association would have us believe that the old laissez faire evolution is good enough today because it was supposedly good enough yesterday."

There is still another explanation which is at least equally important. The American Medical Association represents a vested economic interest of considerable magnitude. Its annual budget is largely financed by the net profit of the *Journal,* which amounted to $600,000 in 1935. This profit is in turn dependent upon the advertising income of the *Journal*—over $780,000 in the same year. Our annual per capita bill for medicines—$5.50—is much higher than it need be. Health insurance would deflate it radically—and also, in all probability, reduce the advertising income of the *Journal,* even though one grants that this advertising is honestly and capably censored by the Council on Pharmacy and Chemistry and other A.M.A. committees. With regard to advertising, therefore, there emerges an unfortunate "community of interest" between the A.M.A. *as a business* and the drug and medical supply industry.

The Role of the Drug Business

IN England and in Germany the insured workers are provided with necessary medicines—nostrums are of course excluded —at an average annual per capita cost of from $1 to $1.50. Even in America, large-scale group-practice and group-prepayment organizations achieve approximately the same economies

and also reduce very radically the purchase and consumption of both "ethical" and "unethical" proprietary medicines.

The economic motivation of the drug interests in opposing health insurance is clear. Recently the opposition became overt when the president of a large corporation manufacturing "ethical proprietaries" which were advertised in the *Journal* of the A.M.A., volunteered a substantial contribution to a fund of $400,000 a year to be raised by the "ethical" drug industry for the purpose of helping the A.M.A. to fight "socialized" medicine.

Laymen who wish to understand the play of vested economic interests in this situation are urged to read almost any issue of *Medical Economics,* a publication supported wholly by advertising and mailed free to 140,000 American physicians.

Social Action—The Role of the Public

As already intimated, the opposition to health insurance is likely to be self-defeating in the end. However, this will be true only if the lay public, the consumers of medical services, plays a vigorous and informed role in the matter. In other countries health insurance has had to wait until organized labor made it a major plank in its platform and program. This has not yet happened in America, although in 1935 the American Federation of Labor passed a resolution endorsing the basic principle of compulsory health insurance. The growing American cooperative movement is also a factor on the side of progress. Finally, progressive churchmen of all denominations may well consider putting health insurance close to the top of the list of current social agenda.

Two forms of social action are almost equally important and practicable: (1) the support of current efforts to establish

group-practice and group-prepayment organizations, especially medical cooperatives; (2) the support of well-considered legislation such as the model bill which has been introduced in a number of state legislatures by the American Association for Social Security. This bill provides both medical and cash disability benefits to all manual workers and to all persons earning less than $60 a week. The costs, paid by the government, the employer, and the employee, are higher for workers who earn large salaries and lower for others.

Because of the current difficulties affecting the administration of the Social Security Act, the prospect of federal action on health insurance is not immediate. But there is every reason to suppose that an adequate mobilization of public opinion might result in the passage of state legislation, to be followed in due course by federal enactments. That this can be accomplished without a good deal of more or less acrimonious controversy is too much to hope for. But the issue is crucial to the well-being of the American people. It has been too long postponed and evaded. The demonstrated price of further evasion is prohibitive. The facts are found, the solutions are charted. We should go ahead.

The right to health is as clearly ours under the constitution as is the right to life, liberty, and the pursuit of happiness. We must fight for this right, coolly, persistently, determinedly.

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ACKNOWLEDGMENT OF ILLUSTRATIONS

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